Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTH TEXAS REHABILITATION CENTER
214 W COLORADO BLVD
DALLAS TX 75218

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
COMPANION PROPERTY & CASUALTY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-4486

MFDR Date Received
AUGUST 1, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have been denied our claims by the carrier's attorney for an extent issue, an issue that has been made up by them to not pay our bills. You can clearly see by our HCFA bills we treated for diagnosis codes 847.2 and 847.0 which are strains of cervical and lumbar only. We have never charged for any other treatment. When you look further the pre-authorizations letters do not list what diagnostic codes were approved. Basically the pre-authorizations letters for our treatment just state approval for the treatment we stated…"

Amount in Dispute: $21,672.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated August 24, 2011: "Contrary to provider's assertion that the carrier is 'playing' the system and 'making a mockery' of the workers' compensation system, the reverse is true. The provider is making false and misleading statements in order to recover payment for workers' compensation benefits they would not otherwise be entitled to. The provider alleges that 'you can clearly see by our HCFA bills we treated for diagnosis codes 847.2 and 847.0 which are strains of cervical and lumbar only' and that they have never 'charged' for any other treatment. They further allege that 'the preauthorization letters do not list what diagnostic codes where [sic] approved.' The provider obtained preauthorization for treatment to conditions not accepted by the carrier as compensable. And then, knowing that the bills would be denied on extent of injury for that reason, changed the codes used for billing purposes to codes were accepted by the carrier as part of the compensable injury – 847.2 and 847.0. The carrier is this case accepted cervical and lumbar sprains as compensable. While it is true that the carrier accepted as compensable the diagnosis codes for strains that the provider put on the bills, the provider attempts by these statements to mislead DWC by failing to mention the fact that when they requested the services, they DID NOT request the services to treat the simple strains. One of their request is included in this response as an example (**Exhibit B**). The request is dated 12/9/10 and it uses ICD-9 codes 307.89, 311, 300.00, V71.09, 723.3, 722.10 and 338.4. Certainly it is obvious by reference to DWC's own treatment guideline that work-hardening and chronic pain management would not be medically necessary to treat strains. If the provider has used these diagnosis codes in its *request* for the services, they would not have been approved as medically necessary through the preauthorization process. A copy of the preauthorization approval for the 12/9/10 request is provided at **Exhibit C**."

Supplemental Response dated August 30, 2011: "As referenced in the initial response, enclosed please find North Texas Rehabilitation Center's *request* for preauthorization for workhardening [sic] sent to the carrier through its third-party administrator on October 26, 2010. Also enclosed is the letter from Broadspire giving notice that the requested services were preauthorized. Please note that this request also does not list the approved diagnoses codes for the accepted lumbar sprain/strain injury, but instead references ICD-9 codes 307.89, 311, 300.00, V71.09, 723.3, 729.2, and 722.10. Using this tactic, the provider changed the billing codes on bills to conform to the accepted diagnoses, and not the diagnoses that were used to justify the preauthorization."

Response Submitted by: Stone, Loughlin & Swanson, LLP, PO Box 30111, Austin, TX 78755

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 1, 2010 November 2, 2010 November 3, 2010 November 5, 2010	CPT Codes 97545-WH and 97546-WH	$1,672.32	$0.00
November 23, 2010 Through January 3, 2011	CPT Code 97799-CP-CA	$20,000.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 320 – Non-accredited interdisciplinary program. Payment reduced 20% below MAR or 20% below usual and customary.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - 45 Charges exceed your contract/legislated fee arrangement.
   - 793 – Reduction due to PPO contract.
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - P11 – Allowance was reduced as per contractual agreement.
   - W1 – Workers Compensation State Fee Schedule adjustment.
   - BILLS ARE DENIED BECAUSE THE DIAGNOSES CODES ON THE BILLS ARE NOT THE DIAGNOSIS CODES THAT WERE USED IN THE REQUEST FOR PREAUTHORIZATION AND UPON WHICH THE CARRIER'S PREAUTHORIZATION WAS BASED. THE DIAGNOSIS CODES USED ON THE REQUEST FOR PREAUTHORIZATION WERE DISPUTED BY THE CARRIER, THUS THE SERVICE AS PREAUTHORIZED WAS NOT TREATMENT OF THE ACCEPTED COMPENSABLE INJURY. PREAUTHORIZATION WAS NOT REQUESTED TO TREAT THE DIAGNOSES CODES APPEARING ON THE BILL AND THERE HAS BEEN NO DETERMINATION THAT THE SERVICES BILLED FOR ARE MEDICALLY NECESSARY TO TREAT THE DIAGNOSES ON THE BILLING.
   - THE INITIAL PAYMENT WAS ISSUED IN ERROR. PLEASE REFUND THE AMOUNT OF $81.92 PAID ON CHECK # 1294793 DATED 12/15/10.
   - 230 – NOT AUTHORIZED
   - 244 – UNNECESSARY MEDICAL
   - 320 – 20% below MAR pr 20% below U&C
   - 741 – Date of service not authorized
   - 790 – Standard reduction
   - 741 – Per the adjuster – Date(s) of service not authorized for payment for this treating provider.
   - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
   - PREVIOUS DENIAL UPHELD: BILLS ARE DENIED BECAUSE THE DIAGNOSES CODES ON THE BILLS ARE NOT THE DIAGNOSIS CODES THAT WERE USED IN THE REQUEST FOR PREAUTHORIZATION AND UPON WHICH THE CARRIER'S PREAUTORIZAITON WAS BASED…
   - 230 – Treatment not authorized

- 38 – Services not provided or authorized by designated (Network/primary care) providers.

Issues

1. Did the requestor obtain preauthorization for treatment to the compensable injury?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600(p)(4) and (p)(10) non-emergency health care requiring preauthorization includes all non-exempted work hardening or non-exempted work conditioning and chronic pain management/interdisciplinary pain rehabilitation. The requestor states "When you look further the pre-authorizations letters do not list what diagnostic codes were approved. Basically the pre-authorizations letters for our treatment just state approval for the treatment we stated…" Review of the preauthorization approvals do not list the diagnosis codes; however, the respondent submitted two preauthorization requests from the requestor. The requestor used diagnosis codes: 307.89 (Other and unspecified special symptoms or syndromes, not elsewhere classified), 311 (Depressive disorder, not elsewhere classified), 300.00 (Anxiety state, unspecified), V71.09 (Other suspected mental condition), 723.3 (Cervicobrachial syndrome (diffuse)), 729.2 (Neuralgia, neuritis, and radiculitis, unspecified), 722.10 (Lumbar intervertebral disc without myelopathy) and 338.4 (Other chronic pain). Neither of the requests for preauthorization document the diagnosis codes for the compensable injury which are 847.2 (Lumbar sprain and strain) and 847.0 (Neck sprain and strain).

2. Review of the submitted documentation finds that the requestor did not obtain preauthorization for the compensable injury diagnosis. As a result reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is not due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		January 31, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.